Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CORRIDOR MEDICAL CLINIC
1348 HIGHWAY 123 SOUTH SUITE A
SAN MARCOS TEXAS 78666

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-11-3522-01

MFDR Date Received
June 14, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In our reconsideration letter to the carrier, we stated this rule and the fact that on the employee's prior visit, date of service (DOS) 1/04/11, the employee was returned to work with restrictions and on the DOS at hand, 3/10/11,the employee was returned to work with no restrictions."

Amount in Dispute: $15.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Rule 129.5 governs work status reports, code 99080-73. The Rule indicates the treating doctor or the referral doctor completes the work status report. In this dispute a nurse completed the report for date 3/10/11. (See requestor's DWC-60 packet.)"

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 10, 2011	99080-73	$15.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §129.5 sets out the procedure for the work status report.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - CAC-W1 – Workers compensation state fee schedule adjustment.
   - 248 – DWC-73 in excess of the filing requirements; no change in work status and/or restrictions; reimbursement denied per rule 129.5
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 724 – No additional payment after a reconsideration of services, for information call 1-800-937-6824.

Issues

1. Did the requestor complete the DWC-73 in the form and manner prescribed by §129.5?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §129.5 states in pertinent part, "(a) As used in this section (1) the term "doctor" means either the treating doctor or a referral doctor, as defined by §133.4 of this title (relating to Consulting and Referral Doctors);"
2. Pursuant to §129.5 (b)(4), the doctor [emphasis placed] shall file a Work Status Report in the form and manner prescribed by the Commission and include an explanation of how the employee's workers' compensation injury prevents the employee from returning to work (if the doctor believes that the employee is prevented from returning to work).
3. Review of the DWC-73 work status report (doctor's signature section) revealed that the requestor did not meet the documentation requirements for completing the DWC-73. As a result, the DWC-73 does not was not completed in the form and manner prescribed by §129.5 and reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 12, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.